There are several HIPAA related pieces of news below:

1) At our HIPAA Website www.dmh.cahwnet.gov/hipaa2001/3.asp we have OHI's Kickoff Meeting invitation available. This meeting is for state and county participation only. Please contact Elaine Scordakis at (916) 651-8065 to register for this event:

Office of HIPAA Implementation (OHI):
BluePrint for HIPAA Success (pdf) (document available at the site)
Kickoff Meeting & Discussion of the HIPAA Assessment Tool
Nov 16, 2001 9:00 a.m. 714 P Street Auditorium
OHI HIPAA Assessment document (document available at the site)

2) Each of the X12N Implementation Guides originally published May 2000 and adopted for use under HIPAA have had addenda created for them. Please see the note below for details.

Please be sure to note that in some cases the information presented may be the opinion of the original author. We need to be sure to view it in the context of our own organizations and environment. In some cases you may need legal opinions and/or decision documentation when interpreting the rules.

Many thanks to all who contributed to this information!!!
Have a great day!!!
Ken

Items included below are:

X12N Implementation Guides Adopted For Use Under HIPAA -- Addenda
[hipaalert] HIPAALERT, Vol. 2, No. 13, Oct. 29, 2001 (attached)
Certification - proposed security rule
[hipaalive] GENERAL: HIPAA Delay Bill just introduced yesterday (10/31/1) S.836
JCAHO
paper on testing and certification
[hipaalive] acronyms
[hipaalive] GENERAL: Psychotherapy Notes
[hipaalive] GENERAL: HIPAA & Dentistry

********** X12N Implementation Guides Adopted For Use Under HIPAA -- Addenda **********
>>> "Steve Bass" <steve@exchange.wpc-edi.com> 10/31/01 04:05PM >>>
ANNOUNCEMENT

Each of the X12N Implementation Guides originally published May 2000 and adopted for use under HIPAA have had addenda created for them. Since these guides were named for use under HIPAA, these Draft

Addenda will go through a Notice of Proposed Rule Making (NPRM) process, just as the original Implementation Guides did, before becoming a final addenda to the guides published by X12N. Only the modifications noted in this Draft Addenda will be considered in the NPRM.

For more information and to download the Addenda:
http://www.wpc-edi.com/hipaa/addenda
<http://www.wpc-edi.com/hipaa/addenda>

Steve Bass

********** Certification - proposed security rule
****
*** This is HIPAAlive! From Phoenix Health Systems ***

Certification under the proposed security rule is well defined and the process is spelled out in many security documents (NIST. DITSCAP, NIACP) and several textbooks on security management. It is security certification not HIPAA certification. Security certification might be done on: Applications in the development life cycle, applications already in production, General Support Systems (GSS), Network, Internet/WEB, COTS, Business Associates or Partner. Certification is one side of a two step process. Certification being the process of establishing a baseline for the security posture of a system or application, determining if the system/application meets a set of minimal security requirements, and verifying that protective measures have been implemented and are working. The second part, accreditation is the formal management acceptance of any residual risks that exist one the system/application has been fully secured. C&A is mostly done in the government, contracted development services, and financial institutions which are considered critical infrastructure companies under PD 63. There are several work groups that are developing commonly accepted security practices and one of those practices will be certification and accreditation (CIO council, CASPR). I have been helping companies develop certification programs for the past 10 years and it causes quite a culture shock in the development side of IT.

Walter S. Kobus, Jr., CISSP, MSTI
Total Enterprise Security Solutions, LLC

*** This is HIPAAlive! From Phoenix Health Systems ***

Certification, in the context of security, is mentioned under the Administrative Procedures.

http://aspe.os.dhhs.gov/admnsimp/nprm/sec06.htm

Short version is that the organization is certifying that they have the appropriate security systems and procedures and they can do their own certification or use an outside party. Since this part of the law hasn't passed, and the section goes on to solicit comment about the implications of an organization doing their own certification or not, I would check this section again when the law is passed.

As others have said very well, certifying software wouldn't make sense in this context.

Hope this helps,
Esther

**** [hipaalive] GENERAL: HIPAA Delay Bill just introduced yesterday (10/31/1) **********
*** This is HIPAAlive! From Phoenix Health Systems ***

fyi. This is the text of a bill replacing S.836, that would call for a one year delay in the transactions andcode sets compliance.
107th CONGRESS

1st Session

S. 1588
To provide a 1-year extension of the date for compliance by certain covered entities with the administrative simplification standards for electronic transactions and code sets issued in accordance with the Health Insurance Portability and Accountability Act of 1996.

IN THE SENATE OF THE UNITED STATES

October 30, 2001
Mr. CRAIG (for himself, Mr. DORGAN, Mr. GRASSLEY, Mr. BAUCUS, Mr. CRAPO, Mr. BAYH, Mr. BENNETT, Mr. CARPER, Ms. COLLINS, Mr. ENSIGN, Mr. HOLLINGS, Mr. HUTCHINSON, Mr. INHOFE, Mr. KYL, Mrs. LINCOLN, Mr. MURKOWSKI, Mrs. MURRAY, and Mr. SMITH of Oregon) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL
To provide a 1-year extension of the date for compliance by certain covered entities with the administrative simplification standards for electronic

transactions and code sets issued in accordance with the Health Insurance Portability and Accountability Act of 1996.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 1-YEAR EXTENSION OF DATE FOR COMPLIANCE BY CERTAIN COVERED ENTITIES WITH ADMINISTRATIVE SIMPLIFICATION STANDARDS FOR ELECTRONIC TRANSACTIONS AND CODE SETS .

(a) IN GENERAL- Notwithstanding section 1175(b)(1)(A) of the Social Security Act (42 U.S.C. 1320d-4(b)(1)(A)) and section 162.900 of title 45 of the Code of Federal Regulations--

(1) a health care provider shall not be considered to be in noncompliance with the applicable requirements of subparts I through N of part 162 of title 45 of the Code of Federal Regulations before October 16, 2003; and

(2) a health plan (other than a small health plan) or a health care clearinghouse shall not be considered to be in noncompliance with the applicable requirements of subparts I through R of part 162 of title 45 of the Code of Federal Regulations before October 16, 2003.

(b) SPECIAL RULES-

(1) RULES OF CONSTRUCTION- Nothing in this section shall be construed--

(A) as modifying the October 16, 2003, date for compliance of small health plans with subparts I through R of part 162 of title 45 of the Code of Federal Regulations; or

(B) as modifying--

(i) the April 14, 2003, date for compliance of a health care provider, a health plan (other than a small health plan), or a health care clearinghouse with subpart E of part 164 of title 45 of the Code of Federal Regulations; or

(ii) the April 14, 2004, date for compliance of a small health plan with subpart E of part 164 of title 45 of the Code of Federal Regulations.

(2) APPLICABILITY OF PRIVACY REQUIREMENTS TO CERTAIN TRANSACTIONS PRIOR TO STANDARDS COMPLIANCE DATE-

(A) IN GENERAL- Notwithstanding any other provision of law, during the period that begins on April 14, 2003, and ends on October 16, 2003, a health care provider or, subject to subparagraph (C), a health care clearinghouse, that transmits any health information in electronic form in connection with a

transaction described in subparagraph (B) shall comply with the then applicable requirements of subpart E of part 164 of title 45 of the Code of Federal Regulations without regard to section 164.106 of subpart A of such part or to whether the transmission meets any standard formats required by part 162 of title 45 of the Code of Federal Regulations.

(B) TRANSACTIONS DESCRIBED- The transactions described in this subparagraph are the following:
(i) A health care claims or equivalent encounter information transaction.
(ii) A health care payment and remittance advice transaction.
(iii) A coordination of benefits transaction.
(iv) A health care claim status transaction.
(v) An enrollment and disenrollment in a health plan transaction.
(vi) An eligibility for a health plan transaction.
(vii) A health plan premium payments transaction.
(viii) A referral certification and authorization transaction.
(ix) A transaction with respect to a first report of injury.
(x) A transaction with respect to health claims attachments.

(C) APPLICATION TO HEALTH CARE CLEARINGHOUSES- For purposes of this paragraph, during the period described in subparagraph (A), an entity that would otherwise meet the definition of health care clearinghouse that processes or facilitates the processing of information in connection with a transaction described in subparagraph (B) shall be deemed to be a health care clearinghouse notwithstanding that the entity does not process or facilitate the processing of such information into any standard formats required by part 162 of title 45 of the Code of Federal Regulations.

(c) DEFINITIONS- In this section--

(1) the terms `health care provider', `health plan', and `health care clearinghouse' have the meaning given those terms in section 1171 of the Social Security Act (42 U.S.C. 1320d) and section 160.103 of part 160 of title 45 of the Code of Federal Regulations;

(2) the terms `small health plan' and `transaction' have the meaning given those terms in section 160.103 of part 160 of title 45 of the Code of Federal Regulations; and

(3) the terms `health care claims or equivalent encounter information transaction', `health care payment and remittance advice transaction', `coordination of benefits transaction', `health care claim status transaction', `enrollment and disenrollment in a health plan transaction', `eligibility for a health plan transaction', `health plan premium payments transaction', and `referral certification and authorization transaction' have the meanings given those terms in sections 162.1101, 162.1601, 162.1801, 162.1401, 162.1501, 162.1201, 162.1701, and 162.1301 of part 162 of title 45 of the Code of Federal Regulations, respectively.

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********** JCAHO
****
*** This is HIPAAlive! From Phoenix Health Systems ***

Harry, In the July, 2001 issue of Joint Commission Perspectives, JC announced they would not survey for HIPAA compliance but hospitals could expect more intense survey of Management of Information standards, specifically security. Evidently, they will soon release revisions to the IM standards which will cover security of information/information systems. Also, they are working to have themselves removed from the business associate category in order to eliminate the barrier to accessing necessary information for accreditation purposes. In other words, they do not want a contract that limits their access to information during surveys.
In answer to your question, I understand that hospitals may choose not to participate in the JC accreditation process, BUT must undergo a Medicare accreditation under the conditions of participation. We are a 425 bed acute care hospital. Several years ago, Medicare notified us they would perform a survey following the scheduled JC survey and they delegated the responsibility to the MS State Department of Health. I understand that there are hospitals across the country that have decided to take this course of action rather than participate in the JC surveys.
Diane Mitchell
Special Projects Coordinator
Memorial Hospital
Gulfport, Ms

********** [hipaalive] New HHS FAQs as of 11/02/2001
****
*** This is HIPAAlive! From Phoenix Health Systems ***

HHS has just posted a new group of submitted questions and answers on the main Administrative Simplification web site. I am including them as reformatted below for you convenience.

<< Begin HHS 11/02/2001 FAQ Quotes >>

11/2/2001 Question 1: Does the Transactions Rule affect health plan transmission requirements? May a health plan continue to require health care

providers to send dental claim transactions to one location (electronic mail box, etc.) and preauthorization transactions to another?

11/2/2001 Answer 1: The Transactions Rule does not affect transmission requirements, such as specified billing addresses, of health plans. These are business decisions between health plans and health care providers. HIPAA does require health plans to accept the electronic transactions which were adopted through the transaction rule.

11/2/2001 Question 2: Is a health plan required to use the standard transaction when performing coordination of benefits (COB) with an automobile insurance company?

11/2/2001 Answer 2: Property and casualty insurance programs are not included within the definition of health plan, so they are not required to use the standard transactions. However, they may do so if they wish, and if they use the standard COB transaction in performing coordination of benefits with a health plan with which they have trading partner agreements to conduct COB, the health plan is required to accept the standard transaction.

11/2/2001 Question 3: Our business provides administrative services to large group physician practices. As part of this service, we collect demographic and clinical information from hospitals and other venues where the group physicians perform services. We send this information electronically to the physicians' billing offices to use in preparing bills to send to various health plans. Do these transmissions have to be in HIPAA standard format?

11/2/2001 Answer 3: The activity you describe does not meet the definition of a health claim transaction or any other transaction for which standards have been adopted under 45 CFR Part 162, subparts K through R. These transmissions therefore do not have to be conducted as standard transactions. The bills sent by the physicians' billing offices to the health plans must be in standard format.

11/2/2001 Question 4: If a health care provider electronically conducts a non-compliant transaction (transmits an old National Standard Format or a proprietary format) directly to a health plan after the transaction regulation compliance date, and the health plan accepts and processes the non-compliant transaction, who is in violation of the regulation? Is it the health care provider or the health plan?
Does the acceptance and processing of a non-compliant transaction by a health plan from a health care provider constitute a violative trading partner agreement between the health plan and the health care provider?

11/2/2001 Answer 4: If a health care provider electronically conducts a non-standard transaction with a health plan after the transaction regulation compliance date, the health care provider and the health plan are both out of compliance. Section 162.923(a) of the rule requires a covered entity conducting an electronic transaction for which a standard has been adopted with another covered entity to conduct it as a standard transaction.

If the health plan by agreement required the health care provider to conduct non-standard electronic transactions, such agreement would not by its terms violate section 162.915. However, if either party were to abide by the agreement, they would be out of compliance with section 162.923(a), for the reason stated above.

11/2/2001 Question 5: As a health plan we currently only conduct coordination of benefits (COB) with Medicare. Does the transaction and code set regulation require health plans to conduct COB with all health plans and health care providers even though they may not currently conduct COB with those entities?

11/2/2001 Answer 5: No. It is the health plan's decision as to whether they coordinate benefits electronically with another health plan or a health care provider. If a health plan decides to coordinate benefits electronically with another health plan or a health care provider, they must use the standard transaction for COB.

<< End HHS 11/02/2001FAQ Quotes >>

The most interesting of these from my perspective is item number 4. This answer clarifies that the acceptance of a non-compliant electronic transaction format is a violation for both the sending and receiving parties, and not just the submitting party. We had a conflict of authority on this issue on this list a few months ago. My point then was that the transaction rule becomes self-enforcing under this interpretation, since you would need legal signoffs by all associated trading partners to use an alternate format, which wouldn't generally be practical to achieve.

- Zon Owen -

********** paper on testing and certification
****
*** This is HIPAAlive! From Phoenix Health Systems ***

Certainly HIPAA's transactions can be certified as compliant and a vendor who could provide certification that their system is capable of producing, exchanging and using compliant transactions would be ahead of the game at this point. WEDI-SNIP has an excellent paper on testing and certification.

It's a must read for anyone involved in the implementation of transactions.
http://snip.wedi.org/public/articles/testing030901.pdf

Marcallee Jackson
Long Beach, CA
562-438-6613

********** [hipaalive] acronyms
****
*** This is HIPAAlive! From Phoenix Health Systems ***

Regarding acronyms and definitions, try these links (two are serious, one not-so-serious):
http://www.acronymfinder.com/
http://whatis.techtarget.com/
http://chronicle.com/free/it/jargon.htm

Liz Allan, RHIA
FYI Deliverex

********** [hipaalive] GENERAL: Psychotherapy Notes
****
*** This is HIPAAlive! From Phoenix Health Systems ***
There is no HIPAA requirement that you separate psychotherapy notes from the
rest of the medical record.

In the HIPAA privacy regulation the term "psychotherapy notes" refers to "process notes" rather than "progress notes." Assessments of the current state of the patient, symptoms, the theme of the psychotherapy session, diagnoses, medications prescribed, side effects, and any other information necessary for treatment or payment are not considered to be "psychotherapy notes."

What the HHS regulators had in mind were notes that capture the therapist's impressions about the patient, to be used by the therapist for future sessions. These notes typically contain details of the psychotherapy conversation that the therapist considers not to be appropriate for inclusion in the medical record. They are, in essence, notes that the therapist writes to himself or herself.

This distinction is explained in some detail on Federal Register page 82622.

It is important to note, however, that if you have material in the medical record that you wish to treat as "psychotherapy notes" you must separate it. For example, should you wish to cite ? 164.524(a)(1)(i) in denying a request

for access, the materials can not be considered (for HIPAA purposes) to be "psychotherapy notes" if they are maintained with the rest of the medical record.

Bye for now -- Harry

Harry E. Smith, CISSP
Timberline Technologies LLC

********** [hipaalive] GENERAL: HIPAA & Dentistry **********
*** This is HIPAAlive! From Phoenix Health Systems ***

..... for dentists. Also, check out www.ada.org/goto/HIPAA for more details.

Take care, Adam!
John